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LEBER'S DISEASE (HEREDITARY OPTIC ATROPHY).

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Though I have here only two cases and nothing to add beyond what is already known of this condition, I think the cases are well worth recording, as it is a rare condition.

So far, comparatively few cases have been described, and none in Australian medical literature, and, until the last few years, there has been no mention of the condition in text-books on ophthalmology. Further, I think that if attention is brought to the condition, other cases may be recognized that would otherwise be passed over, since one of these cases has been to two of our leading ophthalmic surgeons, each of whom gave a different diagnosis, and each, I think, erroneous. I am indebted to a paper by Habershon in the transactions of the Ophthalmological Society of the United Kingdom (Vol. VIII.) for information on the subject.

In a paper by Leber (*Archiv. für Ophthalm.*, Vol. XVII., 1871), the known cases and early literature are collected together.

Since then other series of cases have been recorded from time to time by Habershon, Fuchs, Nettleship, Hutchinson and others.

To generalize, one may say that this is a hereditary affection, sometimes transmitted through several generations, in which the male members of the family are frequently affected, the female members seldom (yet it is they who transmit the disease), children of the same unaffected mother by different fathers having been recorded as affected.

In practically none of the cases has there been any consanguinity of parents. Syphilis and constitutional taint appear to have nothing to do with it.

There is almost total blindness, developing in both eyes simultaneously, or nearly so, in patients otherwise apparently healthy, though often of the neuro-pathic type, subject to headaches, vertigo, tremors, numbness, etc.

The onset usually occurs shortly after puberty, but cases have been reported affecting individuals ranging from the ages of 5 to 43 years.

The loss of vision is seldom total, but usually progresses within a few weeks or months to a certain marked degree and then remains practically stationary, though in a few cases recovery is reported to have occurred. Leber based his description of the condition on 15 cases of his own, occurring in four families, and three cases of v. Graefe's in a single family. Later he collected other cases, totalling 53 cases for 16 families.

The patient first notices that his central vision is becoming worse, and this rapidly progresses till there is a complete central scotoma, and he can barely count fingers a few inches from his face. Leber specifically states that the field of vision is

not contracted, in this way differing from cases of optic atrophy associated with spinal disease. Occasionally during the onset, there are subjective phenomena, such as flashes of light, showers of sparks, etc. Unlike tobacco amblyopia, the patient does not see better in a subdued or dim light. According to Leber's description, the ophthalmoscopic appearances show very little change at first, though there may be haziness or hyperæmia of the papilla, sometimes with spots, streaks, or white lines along the vessels (in fact, the appearance of a mild optic neuritis); but, generally speaking, there is a striking absence of changes in the fundus, though later there is marked pallor of disc, especially of temporal half.

Since this description by Leber, several cases have been recorded, all conforming more or less to this description. In many cases no hereditary element could be proved, but merely a collateral one, the affection being confined to brothers (or occasionally to sisters) or appearing in cousins without proof of previous generations being affected.

In the *Transactions of the American Ophthalmological Society of Boston* for 1880-84, Norris described two cases, in cousins. The family history was very interesting. Five generations were affected in a direct line, beginning with the maternal great-great-grandfather, next the great-grandfather, then the grandmother, next the mother and the uncle of the two patients.

Here we have the condition apparently transmitted in some cases by the males, but it appears to me that in these cases there is room for much fallacy, and as it would involve a period before the days of the ophthalmoscope, the diagnosis must have been built up largely on hearsay and family tradition.

The notes of my own cases are as follows:—

G.H., 34 years, unmarried, has always had very good vision. He had been a farm labourer since leaving school, living an open-air tent life, and had always been very healthy. In middle of March, 1913, on picking up paper, he noticed he could not read, the print being blurred and clouded. For the next couple of months his vision had got worse; since then it had remained stationary. Five or six weeks after the commencement, he noticed some dull pain in the back of the head, and some aching in the eyes and temples, which lasted for a few days. He had been a moderate smoker, 3 or 4 pipes daily, but had stopped tobacco two months after the onset of trouble. He denied any venereal trouble, though he admitted having "risked it" often enough. He volunteered the information that in order to see objects at all, he had to look to one side or above or below. He noticed "showers of sparks" at the time when his head was aching.

Examination 4.10.13. The pupils were equal, and reacted to convergence. They contracted sluggishly

to light, but on continued exposure they dilated again and remained so dilated. They dilated fully to mydriatics. The media were absolutely clear. There were no signs of glaucomatous cupping. The temporal halves of both discs were atrophic; the *lamina cribrosa* were exposed. The maculae of each eye showed a slight granular mottling, but not more, in my opinion, than is seen in many patients with "normal" vision. Otherwise the fundus appeared to have been healthy, save that the arteries were slightly contracted.

Fields.—Right eye: He did not recognize red or green anywhere in the field. Left eye: He recognized red in a small area only, just beneath the point of fixation.

Each eye showed central scotoma for white (10 mm²). The fields were not contracted peripherally for white. The tension (Schiotz) was 18 mm. of Hg.

There were no signs of a spinal cord affection; there was no numbness; no anaesthesia, and no formication; the muscle sense was good. No nystagmus occurred on extreme rotation. The knee jerks were fairly active. Romberg sign was absent. The plantar reflex gave a flexor response. There were apparent signs of trouble of the accessory nasal sinuses. The sense of smell and of hearing were normal. Urine, Sp. Gr. 1015 acid; no albumin; no sugar.

Three months later there was practically no change, except that the patient had at that time no perception of red at all with the left eye.

On holding up a multi-coloured card (each colour 2 in. square), he was able to recognize blue in the periphery of field, but no other colour.

Case 2.—A.S., cousin of patient 1 (sons of two sisters), *et.* 38 years. The patient was married, but had no children. He had been working as a gold miner at the time of the onset. He stated that he "always had splendid sight."

As in the case of his cousin, he had always enjoyed good health, and the examination showed no sign of constitutional taint. The sight had been failing for six years. He first noticed a clouding over the centre of print, which extended in area. The vision deteriorated rapidly, so that in four or five weeks he was almost blind. The condition had remained practically stationary since. He had never had any severe illness. The examination revealed a condition practically identical with that in Case 1. There was no peripheral contraction of fields.

So alike are their optic discs and retinal vessels that if they were used as a means of personal identification, these two cases would probably be taken as twin brothers.

There can be no doubt whatever about the diagnosis in these two cases, though, of course, the diagnosis does little more than name the classification under which they come.

The ultimate cause of the disease is quite unknown. Here are perfectly healthy people, who, for no apparent cause, and often in the prime of life, are deprived, almost totally of what is generally conceded to be the most precious of our five senses.

On studying the recorded cases, one is struck by the fact that a large number of them have been smokers. They differ from ordinary cases of tobacco amblyopia in that their vision does not improve on leaving off smoking.

Spinal cord cases rarely show central scotomata, the defects in the fields being usually peripheral contraction or sector shaped defects.

Many hold that the primary lesion in tobacco amblyopia is in the delicate nerve endings in the macular region of the retina, but in cases of Leber's disease, macular lesions would not, of course, account for the defects of colour perception extending to the periphery of the field.

Further, many cases have occurred in girls and in non-smokers. It may be that toxic influences of various kinds are concerned, the hereditary element meaning simply the transmission of an idiosyncrasy or special susceptibility of the nerve fibres concerned.

In these days when eugenics and Mendelism are so much to the fore, the hereditary influence in the transmission of disease is being more and more studied. Nettleship has collected statistics of the effects of heredity in cataract, nystagmus, affections of choroid, of the cornea (nodular and reticular opacity) glaucoma, retinitis pigmentosa, night blindness. The investigations of Karl Pearson and Bateson have done much to throw more light on such conditions. In Leber's disease the transmission appears to follow very closely that of colour blindness, but yet is apparently not identical.

Bateson showed that in the case of colour blindness, if the mother was affected, investigation showed that her father was always colour blind, and that if the mother had sons they would all be affected; but that if the mother merely transmitted, without being herself affected, some sons would be affected and some not.

In Leber's disease, if the mother is affected, some of the sons will usually escape; but here it seems to me conceivable that the hereditary transmission may possibly be the same as in colour blindness, but the necessary contributing factor in after life may be absent in the cases which do not exhibit the disease. Nettleship appears to think that there is some connexion between early onset of Leber's disease and the female sex. According to his investigations, the sufferers are not affected as regards longevity, and the families affected do not seem to be less prolific than others.

To those who attended Bateson's fascinating address on Mendelian phenomena, during the meeting of the British Association in Sydney, it was very interesting to see the mathematical accuracy with which the "dominants" and "recessives" showed up in definite proportions as the result of certain crosses. Possibly, transmission of characteristics follow just as immutable laws in man, though, of course, on the face of it, with aborted pregnancies, early deaths, and the very varying influences brought to bear on the one family of offspring, such laws must always be harder to prove.

The question crops up as to whether we could diagnose these cases, in the event of only a single case coming under our notice.

My first case was so similar to one which I had seen in Prof. Fuch's clinic in Vienna that it led me to enquire at once if he had any relatives affected in the same way as himself.

In any cases showing symptoms of retrobulbar neuritis or of toxic amblyopia, absolute central scotoma, or scotoma for colours, we should always have the condition in mind, and especially in apparent cases of tobacco amblyopia, which do not improve on ceasing to smoke.

Retrobulbar neuritis is no doubt often secondary to sinus trouble, but in genuine cases of Leber's disease, there does not appear to be any connexion.

Treatment unfortunately does not hold out very bright prospects. Some cases have undoubtedly recovered. Nettleship had two patients, one of whom, after being nearly blind, recovered absolutely in nine months, and one in two years. He thinks that some of the recorded miraculous cures of blindness may have been cases of this sort.

The treatment round which most hope seems to centre consists in sub-conjunctival injections of normal saline, and of cyanide of mercury, internal administration of iodide of potassium, and hypodermic injections of strychnine. In my own cases, treatment has been of no avail, and though the patients have been now under observation for over twelve months, the vision during that time has remained stationary.

If anyone has had cases which might fall in this category, and would favour me with a report of the case, I should esteem it a great favour.

TUBERCULIN AS A THERAPEUTIC AGENT.

By **Walter Summons, M.D., D.P.H.,**
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Again and again the question arises, is tuberculin of value as a therapeutic agent? That the answers given are so diverse seems to result from the non-appreciation of the well-known facts that the tubercular infections, and especially the reactions to the infection, are seldom alike in different patients. The treatment of a case of tubercular disease is always an experiment in the immunity processes of a particular patient with respect to the tuberculous infection.

The number of tuberculin preparations on the market is legion, each with a special claim by the makers. Nevertheless tuberculin, both endogenous and exogenous, under all its names, is essentially the same in so far as the local, focal, and constitutional reactions in the human body are concerned. The strength of the preparations, on the other hand, varies enormously, and for practical purposes it is advisable for each practitioner to become accustomed to a particular form of tuberculin, or at the most to employ not more than two or three preparations. By so doing a clearer idea of the dose will be maintained. Under exceptional conditions it may be thought advisable that a more special form of tuberculin, such as the albumose free or the sensitized tuberculin, should be used. So many factors enter

into tuberculin treatment that by the regular use of one tuberculin the problem is always simplified. I have been in the habit of administering Koch's new tuberculin (T.R.) for the majority of cases. This preparation commends itself to me seeing that it practically is a bacillary emulsion, and the dose can be estimated with constancy and accuracy, whereas with B.E. unexpected reactions are met with not infrequently, which render it doubtful whether small increases of doses can be determined. Suppose we have a patient to whom it is desired to give a dose of 1/100,000 mgm. If the bacillary emulsion is not uniform an unbroken clump of bacilli may gain admittance to the dose in addition to the 1/100,000 mgm. A reaction will then occur from which an erroneous idea of the patient's sensitiveness to tuberculin will be obtained.

Having decided on the form of tuberculin a still more important question is the dose to be employed. In the Austin Hospital and similar institutions for advanced cases of tuberculosis the disease in many of the patients runs an afebrile course. Nevertheless they are obviously going down hill, and are not far from a fatal termination. A similar state of non-sensitiveness can be brought about by administering large doses of tuberculin, and rapidly increasing the dose regardless of the resulting reactions. The patients subsequently appear to be more tolerant of their toxins, and they may believe that improvement has resulted from the treatment. Undoubtedly, however, many of these patients have had their end hastened by the violent reactions, and the same degree of tolerance might have been obtained in a manner more agreeable to the patient. The method of avoiding reactions with doses ranging from an initial 1/100,000 mgm. to 1/10,000 mgm., at intervals of 7 to 10 days, is devoid of danger, and in suitable cases this form of treatment will contribute not inconsiderably to the recovery of the patient.

The success or otherwise attending tuberculin treatment depends absolutely on the correct choice of patient. The best guide to the patient's reaction to his autogenous tuberculin is a careful record of the temperature. In this class of case the mouth record may be misleading and useless. The temperature must be the true internal temperature of the body, and is most conveniently taken in the rectum. Further, the possibility of error from a rise of temperature due to exertion must be remembered. To obviate this at least half an hour's rest should be taken before the thermometer is inserted, and it should remain in situ for from 3 to 5 minutes. If the temperature so taken exceeds 100° F. in a male, and 100.4° F. in a female at any time during the 24 hours, tuberculin is contra-indicated. Such a case must be converted from a febrile into an afebrile one by absolute rest. In the event that this has been done, and yet on resuming exercise the temperature rises, the administering of tuberculin should be postponed, or discontinued. It has been found in these cases, where the temperature keeps within normal bounds only during absolute rest, that even minute doses of tuberculin produce constitutional reactions. As a general rule this constitutional reaction to a small dose of tuberculin is a bad prog-

nostic sign, and the tuberculin apparently hastens the patient's progress downhill. When a constitutional reaction results there will probably be a marked focal reaction in addition. If the lungs are the seat of the disease the increase of the cough will cause a further rise of temperature by acting like ordinary exercise. In fact the fever may be an exercise fever, entirely brought about by coughing and not a constitutional reaction to the tuberculin injection. The case must be carefully reviewed, and a lessening of the dose may be necessary. It is preferable to place the patient in a sanatorium for careful observation; but an intelligent patient can help by reporting his own subjective sensations, particularly if he has had previous sanatorium experience.

It is often stated that those patients who are suitable for tuberculin injections are the most favourable class of patients, and that they would get well without the aid of tuberculin. This may be granted in a fair proportion of patients. On the other hand, every practitioner can recall cases in which a temporary improvement was followed by a standstill in spite of the continuance of treatment. It is to these that tuberculin is undoubtedly of the greatest service. This is most obvious in surgical tuberculosis, but what is true of localized surgical foci is also true of localized foci in the lung. Tuberculin, of course, cannot effect a resolution of calcareous deposits or bags of pus with superadded pyogenic infections, into which tuberculous kidneys frequently degenerate. For these, surgical measures must be adopted first, and tuberculin treatment subsequently.

When estimating what initial dose to administer to a patient the patient's reaction to this autogenous tuberculin must be taken into consideration in the first place. It must be determined if his temperature is stable, or if it is easily upset with a minute increase of his own tuberculin circulating in the blood. If a patient's temperature rises as a result of getting out of bed, and reclining on a lounge during the day, even though the rise does not exceed the 100° F. limit, it is not advisable to inject a dose exceeding 1/100,000 mgm. of T.R. The temperature curve for the next 48 hours will decide whether the dose is to be repeated, increased or discontinued. If it is to be increased I usually make the next dose 1/50,000, and feeling my way continue at intervals of 7 to 10 days with these following doses: 1/40,000, 1/30,000, 1/25,000, 1/20,000, 1/15,000, 1/10,000. It is rarely prudent to exceed the last dose save in certain cases of surgical tuberculosis. Not infrequently the same dose may have to be repeated, or the interval may have to be prolonged. It is not advisable to administer tuberculin if the patient is feeling out of sorts, even though it may be from an apparent extraneous cause.

Our aim is to produce a stimulus to the antibody formation with the minimum amount of the negative phase immediately after injection. By increasing the dose too rapidly or overmuch the negative phase is increased, and in course of time the sensitiveness of the tissues is lessened. A dose that will just produce a reaction in the disease focus and its immediate neighbourhood without bringing about a constitutional reaction is the ideal dose. By the injection

of the doses mentioned above the tolerance is increased, and at the same time the sensitiveness is not destroyed. It is essential that the patient rest 48 hours, for even with a negative local reaction a severe focal reaction occasionally takes place on the second day, and this would be exaggerated by exercise.

The improvement resulting from tuberculin treatment is manifested not only by the objective signs, but by the fact that the patients frequently declare that they are conscious of an improvement in their *bien-être*. This is not merely an outcome of the fact that something is being done for the patient. The same patient does not speak of improvement from other special lines of treatment.

A second advantage of tuberculin injections common to all forms of continuous treatment is that the patient is kept under uninterrupted observation, and his habits can be checked, and other details of daily routine watched.

By restricting tuberculin solely to ambulant afebrile patients, the number of cases in which tuberculin can be used is small, not more than 8-10% of those who present themselves for treatment. By so restricting its use harmful results are obviated, and the danger of tuberculin falling into disrepute is done away with. Undoubtedly a careful and judicious employment of tuberculin as a therapeutic measure lessens the duration of illness, increases the number of arrested cases, and probably raises the percentage of cases in which the bacilli disappear from the sputum.

Reports of Cases.

NOTES OF A CASE OF TUMOUR OF THE AUDITORY NERVE.

By R. E. Shuter, M.D.,

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The notes of the following case of tumour of the auditory nerve in which recent methods were successfully employed in the diagnosis are, I think, of sufficient interest to justify publication.

E.D., *æt.* 43, farmer. Three years ago his friends noticed that he was becoming deaf in the right ear, he then had some treatment for catarrh of the ear, without benefit. He next noticed that he was getting attacks of dizziness. These gradually became more severe, and at the time of examination, dizziness was constant. He had no tendency to fall in any definite direction, but could not walk without staggering. He had no headache, loss of weight or vomiting. He thought that the left ear was getting somewhat deaf, and the sight blurred. He had never had discharge or pain in either ear, had had no injury to his head, nor was there any history of syphilis.

Examination (conducted on April 4, 1914).—A tendency to fall to the right and backwards with the head straight was distinct, but not marked. This was more marked when the face was turned to the right shoulder; with the face turned to the left shoulder the equilibrium was more stable.

The patella reflexes were active and equal. The left wrist reflex was more active than the right. The grip by manometer was equal on the two sides; no dysdiadochokinesia was present. There was no spontaneous error in pointing in either elbow or wrist joint, either in testing with alternate pronation and supination, or when the cerebral centre was engaged by the patient performing coincident voluntary movements with the arm not under examination. On the other hand, while the pointing with the

left arm was always accurate, that of the right was hesitating, and at times inaccurate. The error was not constant in direction or always present; this was demonstrated at separate examinations.

An horizontal spontaneous nystagmus was present of the first degree, both to the right and to the left, the minimum angle of deviation to the right being 20° , that to the left 30° ; a vertical nystagmus upwards was present, but not downwards.

Eyes.—The pupils were active to light and accommodation, the media clear. Both optic discs were distinctly blurred. The right side of the face was slightly mask like, but no sensory disturbance was present. One observer thought that slight motor paresis could be detected. When the conjunctiva of the right eye was stroked gently with cotton wool, the contraction of the orbicularis was not as active as that of the left. I satisfied myself on this point at several examinations, and wish to emphasize it, and to advance as a possible explanation that it was due not to conjunctival anaesthesia, but to a weakened motor response, due to a commencing involvement of the facial nerve. Since seeing this case I have examined several cases of recovering facial paralysis, and in some of them have elicited a similar sign. I advance this sign as worthy of examination by other observers. The absence of facial paralysis with the presence of a large tumour of the auditory nerve is not what one would expect, and it is therefore important to determine whether or not any value can be attached to the sign that I have described above.

Special examination of the ear—

Memb. Tymp.	Right Ear.	Left Ear.
	Normal, malleus moveable	Normal, malleus moveable
Watch	Not heard	One-fourth
Whisper	Not heard	Four yards
Conv. Voice	Not heard	Over eight yards
Sound range	None heard	16 to 15,000 D.Y.
Rinne	Nil	With C & C ₂ positive
Weber	Laterallized to the left	

With Barany's noise producer in the left ear, the right ear was completely deaf to shouting and siren.

Caloric Test.—Cold water (78° F.) to the right ear produced no nystagmus, and did not disturb equilibrium; hot water (118° F.) also gave a negative result. Cold and hot water to the left ear gave in each case the usual nystagmus and disturbance in equilibrium.

Turning Chair.—Ten turns clockwise and also counter-clockwise produced in each case the corresponding error in the left elbow joint, but no constant error in the right, the pointing as before was at times incorrect, but not in any constant direction. Seven turns clockwise annulled the nystagmus for 25 seconds, while seven turns counter-clockwise annulled it for 10 seconds.

Operation.—The cerebellum was widely exposed in the usual way by removal of part of the occipital bone, a dural flap laid back, and on lifting up the right lobe the tumour was clearly seen, but its limits not determined, as the condition of the patient forbade any further interference at that time. Unfortunately, the patient did not rally from the operation, but died some sixteen hours afterwards from heart failure, apparently from disturbance of the centres in the medulla.

Postmortem Examination.—A limited examination through the operation wound was allowed. The cerebellum was removed. The tumour was adherent to the *pars petrosa*, posterior to the internal meatus. I saw the specimen several days after removal, and it was difficult to determine the relations of the tumour to the basal nerves; the facial nerve had apparently been torn away in the removal of the specimen. The tumour appeared to be growing from the sheath of the auditory nerve. The pathologist reported that the tumour was a glioma.

Remarks.—There are two points of particular interest in connexion with this case. The assistance gained from the special examination of the ear enabled a positive diagnosis to be made previous to operation, and suggests that when these methods are more fully understood and widely practised, earlier diagnosis will be possible, and the case attacked at a stage when operative interference will offer a greater prospect of success. The second point of interest

is the indefinite disturbance of the centres in the right cerebellar lobe. One could not say that there was any definite spontaneous error in pointing, or any evidence that a definite sub-centre in the cerebellum was destroyed. All that could be determined was that coördination in the right upper limb had ceased to be automatic, and was distinctly disturbed. This sign was puzzling previous to operation, but the examination of the specimen is, on this point, interesting and instructive. The tumour, which was as large as a walnut, had pressed upon and flattened the whole anterior part of the right lateral lobe, probably interfering with the functions of the sub-centres for pointing in all directions, and what is equally interesting, flattening and thinning by pressure the right middle peduncle, which constitutes the tract for the nerve fibres from the voluntary centre in the cerebrum to the sub-centre in the cerebellum for automatic coördination.

HÆMORRHAGE INTO A CAVERNOUS ANGIOMA.

By P. L. Townley, B.A., M.B., Ch.M. (Syd.); and
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Gayndah.

The following case seems worth recording, not as a triumph of surgery, but as one of the curiosities thereof.

One of us (P.L.T.) was called to see a case, of which the history was as follows: The patient was a young man of 21 years of age whose pedigree was one-quarter Australian aboriginal and three-quarters Chinese. His mother stated that at birth he had a "lump" on the lower right jaw, which had grown with him, and lately had become noticeably more prominent. Beyond the deformity, it had never caused him any inconvenience, and consequently had never been examined by a doctor. On January 31, 1915 (which, by the way, and for the information of the Sabbath Observance Society, was a Sunday) he was one of a fishing party. For dessert at lunch they had a water-melon. One of his companions playfully flipped a piece of melon rind at him, striking him just below the right malar bone. Very soon the right side of his face began to swell, and the swelling continued during the night. Next morning he was seen by one of us (P.L.T.), when the right side of his head, face and neck was swollen to an enormous size, about as large as a football, and he had considerable difficulty in breathing. The swelling, which fluctuated, extended as far down as the right clavicle. Behind the right ear was a large purple patch, and a similar one above the right clavicle. There was also a large purple mass distending the mucous membrane of the cheek and projecting into the mouth, as big as one's fist. It was evident that a large proportion of the patient's blood was in his face and neck. He was immediately conveyed to the General Hospital, where one of us (C.T.H.) under chloroform (the administration of which was very difficult, owing to the struggling and dyspnoea of the patient) made an incision in the cheek to discover the source of, and, if possible, to control the hæmorrhage. About a quart of coagulum and fluid blood was expressed, when it became evident that we had to deal with a cavernous angioma. The blood was gushing furiously from numerous large vessels and cavities. When pressure was applied by plugs the breathing became more embarrassed. During our efforts to control the hæmorrhage by plugs and forceps, the patient became pulseless and ceased to breathe. Tracheotomy was immediately performed, and the trachea held open, while artificial respiration was carried on for a quarter of an hour, but this proved unavailing.

One of the points of interest in the case is that the patient should have carried such a tumour for 21 years and passed safely through the blows and falls and fights of childhood and youth without injury to it, and that a fatal hæmorrhage should have been caused by the impact of a piece of melon rind.

Reviewing the case afterwards (a time when we all have the opportunity to think what might have been done), perhaps the best course would have been to perform a tracheotomy, and then occlude the external carotid artery by ligature.

Reviews.

PSYCHIATRY.

"The Brain in Health and Disease,"¹ by Dr. J. S. Bolton, is an ambitious effort "to settle the question of cerebral function on the old-established basis of anatomy and physiology, and of histological and clinical pathology." The work is divided into two parts. The first is of an anatomical and physiological character, general in some parts, and in great detail in others. The grey matter of the visuo-sensory, visuo-psychic, and prefrontal regions has been very carefully examined histologically, and has been measured by a "micrometric" method. From the measurements thus obtained very elaborate diagrams have been prepared, with a normal line in middle, and degrees of amentia (deficient neuronic development) on one side, and of dementia (neuronic degeneration) on the other. A chapter is specially devoted to support the position taken up by the author as to the structure of the prefrontal region, in contradistinction to that of Dr. A. W. Campbell.

The second part of the book is somewhat clinical in character, and different types of amentia and of dementia are discussed very fully. Amentia is defined as "the mental condition of patients suffering from deficient neuronic development," and is subdivided clinically into (a) low-grade amentia, or idiocy and imbecility, and (b) high-grade amentia, including moral, unstable and excited cases, together with recurrent cases of all types, hysteria, epileptic insanity, and true paranoia. Dementia is defined as "the mental condition of patients who suffer from a permanent psychic disability, due to neuronic degeneration following insufficient durability," and is subdivided into (a) a primarily neuronic class composed of senile, presenile, mature and premature types, (b) a progressive and secondary class, which includes senile dementia with gross degeneration of cerebral vessels and general paralysis, and (c) a class of special varieties following sense-deprivation, epilepsy, and cerebral lesions.

Much labour has been spent in the production; many brains have been studied; innumerable sections from certain parts of these brains have been made, and carefully examined. Hundreds of records of cases have been epitomised; the salient points have been brought into evidence, and many plausible deductions have been made. Some of these are original, for example, the statement that "*dementia paralytica* is a branch of mental disease, and the subjects of this mental disease would, if they had not been syphilitized, have suffered from one or other of the types of primarily neuronic dementia." Those interested in mental diseases will find many points of value, even though the book is written in a purely personal manner, with little if any reference to the work of others.

Notes on Books.

INSANITY.

"Insanity in Every-day Practice,"² by Dr. E. G. Younger, is now issued as a third edition. There is little alteration from previous editions, but reference is made to the recently enacted "Mental Deficiency Act." The book is a useful one to the general practitioner, the short chapter on "examination of patient with view to certification" being particularly so. The chapter on "legal bearings" has no local bearing, and the book therefore loses in value in this respect.

THE WELLINGTON HOSPITAL DIFFICULTY.

The town of Wellington, in New South Wales, has 4,400 inhabitants, and the sick are served by five medical practitioners. Four of the doctors are members of the British

Medical Association and have worked steadfastly for the improvement of the medical care of the sick poor and for the maintenance of the honour, dignity, and interests of the medical profession. During the past few years, the Lodge question has been an actual difficulty in Wellington and district. The United Friendly Society's Lodges have resisted the British Medical Association and have refused to adopt the common form of agreement. Incidentally, it may be mentioned that since the beginning of the current year, the Manchester Unity has broken away from the other Friendly Societies, and the local practitioners have been accepted on the terms agreed upon by the Association. This Lodge had but 75 members in January, but to-day it has 150, and it is increasing in strength and importance week by week. One of the medical practitioners in the district, a Dr. Gilbert, applied in April of 1914 for the position as Medical Officer to the United Friendly Society's Lodges and accepted terms which the Association had determined no member should accept. By this action he rendered himself ineligible for membership of the Association. His position, on this account, became a difficult one and the relations with the other practitioners in the town were naturally strained. After a short time it was discovered that he was suffering a disadvantage by not being on the honorary staff of the local hospital. He appears to have complained that his patients were refused admission to the hospital, but it is not clear whether he ever actually sought admission for any of his patients. The members of the honorary medical staff of the hospital maintain that no patient, who was a suitable subject for hospital treatment, was ever refused admission. On one occasion, an enquiry was held by the committee into a charge of neglect, but it was discovered that there was no foundation for this charge.

In January, 1915, Dr. Gilbert made an application to be appointed to the honorary staff of the hospital. In this he was acting within his rights. The three members of the staff, naturally, resisted the appointment. The annual meeting took place, and was attended by some eighteen persons, the majority of whom were members of local Friendly Society Lodges. It was decided that the committee be recommended to appoint Drs. Gilbert and McRae to the honorary staff. The three members of the staff thereupon determined not to apply for re-appointment, in view of the fact that the newly-appointed committee had shown by its actions that but little sympathy was felt with the British Medical Association. A letter signed by Drs. Metcalfe, Savage and Watt was addressed to the committee, calling attention to the "hostile attitude of the subscribers," and intimating that the signatories would not seek re-election, but with the committee's consent would continue to act until the other practitioners had taken up their duties. Dr. McRae withdrew his application.

The position was rendered still more acute by a very extraordinary meeting of the committee, at which the three members of the staff were appointed, in spite of their avowed intention not to apply for election. A further resolution was carried appointing Drs. Gilbert and McRae, subject to the consent of the Minister of Public Health, and a third resolution, thanking the three members of the medical staff for their past services. The sick poor have not suffered during the dispute, but it is the convenience of Lodge patients rather than the urgent needs of the poor that appears to influence the members of the committee in their actions.

Quite recently a medical officer from the Department of Public Health has been investigating the state of affairs, and his report will be laid before the Minister. If the Minister is well advised he will arrange that a special meeting of the subscribers and general public in Wellington be held, and that the whole question of the management of the hospital be decided by this meeting. We have reason to believe that if this course were followed, a fresh committee would be appointed and the difficulty would be overcome. Failing this, it is clear that the members of the old staff cannot again assist in the work of the hospital, as long as the present committee is in power and as long as Dr. Gilbert is attached to the hospital. In the interests of the hospital class—that is, of the poorer section of the community—the exclusion of three or four of the practitioners of the district would be a serious matter.

¹ The Brain in Health and Disease, by J. S. Bolton, M.D., D.Sc., F.R.C.P., 1914. London: Edwin Arnold; Royal Soc., pp. 479.

² Insanity in every-day Practice, by E. G. Younger, M.D., M.R.C.P., D.P.H., 1914. London: Baillière, Tindall & Cox; Crown Soc., pp. 130. Price, 3s. 6d.

The Medical Journal of Australia.

SATURDAY, FEBRUARY 27, 1915.

Charity or State-Aid.

State control and nationalization are in the air. For some time past the medical profession has been asked to listen, like an unwilling school child, to lessons on the advantages of the transfer to the State of all matters affecting health and sickness. The profession has acquiesced quite willingly to the taking over by the State or local authority of the administration of what is termed public health, by which is meant preventive medicine and sanitation in their relations to the general public, as contrasted to the individual. No one would have this otherwise. But the extension of these principles to individual medicine, by which is meant the care of individual patients during sickness, injury or childbirth, involves a change so drastic and so revolutionary that tacit agreement cannot be expected, and active opposition must be anticipated as long as the arguments in favour of this alteration can be met by sound arguments against it. The unwisdom of the policy of placing hospitals and sanatoria under State control has been touched upon on several occasions in these columns. State hospitals can never compare with hospitals run on a voluntary basis, if the former are to be staffed by salaried medical officers. One of the reasons why London is proud of her great charitable hospitals is that the medical profession has joined with the charitable public in providing for the sick poor in a manner that neither would feel inclined to do, if the Government were to pay for the maintenance. Were this feeling of philanthropy removed the result would be half-heartedness and mediocrity in work.

The State of Tasmania has supplied the Commonwealth with a foretaste of what the public institutions for the treatment of the sick poor would be like if they were entrusted to the tender care of the State Governments. The Consumptive Sanatorium of Tasmania has been receiving a subsidy from the Government of £200 per annum. It did not even get the full cost of maintenance. The contribution due

up to December 31, 1914, was provided for, but no further moneys were available until the Appropriation Bill had passed through Parliament, which took place toward the end of January. At this date a further instalment was paid. But in the meantime the institution had got into financial difficulties. The Government was unable to assist, even to a small extent. The Committee was therefore forced to apply to the Southern Tasmanian Friendly Societies' Association for a loan to tide it over a period of embarrassment. In short, the Tasmanian Government has failed to provide part of the amount necessary for the upkeep of this highly important institution during a time when subsidy was added to voluntary contribution. What might occur if the whole financial responsibility and control were taken over by the State can easily be imagined. It may be argued that if the whole responsibility rested with the Government, ample provision would be made to meet the necessary expenditure. But we doubt whether this would be the case. It is well known that hospitals run on economic lines, without any payments being made to the visiting medical staff, cost large sums of money. A careful exchequer would be unwilling to provide more than a bare maintenance if the moneys had to be raised by taxation, direct or indirect. The population could supply an ample, nay generous amount for every hospital in each State, but had these sums to be raised by compulsory methods, grumbling would be heard if the amounts were at all large. On the other hand, human nature is prone to voluntary efforts, and the man who objects to pay his income tax is often proud to place a substantial cheque into the hands of the hospital committee, especially if his name appears on the subscription lists. With small means the value of the work in a hospital diminishes, while with a small margin for innocent extravagances, the work undertaken and achieved is a thing to boast with. The failure of the Tasmanian Government to meet its liabilities in connexion with the Consumptive Sanatorium will be reflected on a larger scale if the Governments of the various States take over the great hospitals and make them second rate asylums for the indifferent care of the sick.

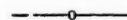
THE SPREAD OF SYPHILIS.

Public scares, like heat waves, appear periodically. In the latter case, the public anticipates the condition, but makes a great fuss when it arrives. In the former, the cause for complaint or alarm is usually present continuously, but the effect is only evidenced when the caprice of the loudest speakers determine. At present, public attention is being directed to the question of venereal diseases, not without good cause. But it is not at all certain that these diseases are more widely spread to-day than they were twenty years ago. There is no means of ascertaining the exact incidence of these affections. In a report issued last year by the South Australian Branch of the British Science Guild (see *Medical Journal of Australia*, July 23, 1914, p. 97), an attempt has been made by its authors to compute the extent of syphilis in South Australia. But no information is given as to even an approximate incidence at various periods. It may, however, be assumed with some confidence that the incidence of syphilis and the extent of alcoholism go in parallel lines. No one can doubt that the consumption of alcohol and the extent of alcoholic excess have diminished very materially during recent years. The national drink bill and the records of the courts prove this.

A special and entirely unforeseen danger of an increased spread of syphilis has arisen in connexion with the war. In a highly picturesque communication by Dr. J. B. Nash, which is printed on another page of this issue, the author states that in Cairo syphilis is rife and highly virulent. A number of our men who volunteered to fight for their country are now returning, not wounded but invalided by syphilis. These men, instead of serving their country in a useful manner, and instead of making sacrifices which, when made, lend splendour to the Empire on which the sun never sets, have wasted their country's money, have soiled their country's name, and are, or might be but for the foresight of those in power, a disgraceful danger to the welfare of the population at home. A member of the first contingent from Australia states that there were 200 of our soldiers under treatment for venereal disease at one time, and he makes the astounding statement that 10% of the whole force has been

infected since leaving our shores. If this be in accord with fact, the safeguards which are being adopted by the military and civil authorities will be insufficient when the war is over and the men return. It is well known that after a war, and indeed during its currency, the world loses its balanced judgement. Women look on khaki-clad men, on account of their bravery and reckless devotion, as heroes all. In the instance of the Cuban War, no secret was made of the fact that the men were petted and caressed to an extravagant extent when they returned. In London, the man in khaki is the darling of women in all grades of society. This means that unless the facts are faced and a rigid programme of education and medical control is carried into effect, the fruits of British victory will be discounted by a heavy entry on the other side of the account.

In regard to the men returning invalided with syphilis, little danger exists. The military authorities have arranged that no soldier will be allowed to land before he has been examined with care. Those who are found to be suffering from syphilis in a contagious stage will be taken to Melbourne and will be detained in hospital until all infectivity has been removed. In regard to the men returning in civilian dress, the Quarantine Department will take effective measures. This has already been carried out in three instances at least. The sufferers are arrested under the Immigration Restriction Act, and placed into quarantine until free from danger to others.



A HOME FOR THE FEEBLE-MINDED.

The annual report of the Committee of the Minda Home, Brighton, near Adelaide, which was presented to the annual meeting held last June, has been issued, and contains some interesting information. The Home was established nearly 17 years ago, the first pupil having been received on May 2, 1898. The object of the Home is to train the feeble-minded and epileptics. The Home is open to the feeble-minded, idiotic, imbecile and epileptic of both sexes, irrespective of age, creed or national distinction. In 1894 a number of influential gentlemen, including the late Sir John Colton, Mr. J. H. Symon, Q.C. (now the Hon. Sir Josiah Symon), the late Mr. George Ash, and Mr. S. Johnson, called attention to the fact that many children were being detained in lunatic asylums who should not be there. Strong representations were made by the late Mr.

Ash to the effect that the children classed under the term "feeble-minded" were capable of being educated if skilled instructors and proper institutional care were provided. The prospect of improvement of these children as long as they were incarcerated in asylums was held to be entirely absent. The effect of a series of articles on this important subject and of the assiduous work of the gentlemen interested in the movement was that the sympathy and practical support of the Government were secured, and toward the end of 1897, a committee formed for the purpose felt justified in starting the work in small premises at Fullarton. The building was ready for the reception of the first pupil in the following year. After some years of activity it was found that the premises were too small for the work and in 1911 a building at Brighton was taken into use. This Home occupies a large area of land, extending over 52 acres, and it is under almost ideal conditions that the feeble-minded and the epileptic pupils are trained in manual work, suited to the degree of intelligence of each individual. The number of pupils admitted is naturally restricted by the means of the institution and the accommodation of the Home. It is therefore essential that preference be given to the younger children and to those whose condition is comparatively amenable to institutional treatment. The Committee, however, recognizes that very important work can be carried out in addition to the actual training of the pupils. It has been pointed out that weak-minded and imbecile girls and boys fill the ranks of the criminals, the prostitute class and the dupes of the unscrupulous. Further, procreation of this class of mental defectives leads to the increase in the number of similarly afflicted persons. One of the functions of an institute for the reception of the mentally defective is to protect them against themselves and against a cruel and vicious world. Unfortunately, the accommodation of the Minta Home does not permit of the admission of many of these unfortunate creatures for custodian purposes.

The pupils are received from all classes of society. In ordinary circumstances, the sum of £40 is charged per annum for each pupil, but reduced fees or gratuitous treatment is accorded as the funds of the institution permit and the requirements of the case dictate.

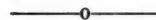
The Home has developed gradually. When the site was purchased, a building with an eastern aspect was equipped for the purpose. A central portion with a western wing was built, and, following on this, a two-storied building at the south end of an extension of the original building was erected and opened in June last. This portion cost £7000, and has accommodation for 80 boys and the necessary staff. The quadrangular institution will be completed by the "Vere" block, the foundation stone of which was laid by Dr. J. C. Verec in October, 1913. This is to be the girls' block, and will be a pendant to the southern block. In the last place, plans have been prepared for an infirmary, which is to cost £650.

The Home contained 77 inmates on March 31, 1913, and 82 on March 31, 1914. During the year, 16

pupils were admitted, 6 were discharged, and 5 died. The cause of death was generalized tuberculosis in one patient, enteric fever in two, pneumonia in one, and epilepsy in one. In all, three of the inmates were attacked with enteric fever. The Medical Superintendent, Dr. J. Stothart Farries, records great difficulty in dealing with these patients, on account of the want of a suitable infirmary.

Twenty-six epileptics were under care during the year, but the accidents were limited to one or two trivial ones. The health of the pupils has been good.

The girls are employed in the laundry, kitchen, sewing-room and dormitories, while the boys assist in the gardens and on the farms. The Medical Superintendent believes in keeping males to what has hitherto been regarded as male work, and females to what has been regarded as female work. He apologises, in our opinion unnecessarily, for this "antiquated" division of labour. In the report, the singularly appropriate words of Dr. Eduard Séguin are quoted to explain the method of carrying out the excellent work of the institution: "To make the child feel that he is loved, and to make him eager in his turn to love, is the end of our teaching, as it has been the beginning. . . . For our pupils, science, art, education, medicine, philosophy, each may do something; but love alone can truly socialize them; those alone who love them are their true rescuers."



THE BRISBANE WATER AND SEWERAGE BOARD.

The Metropolitan Water and Sewerage Board of Brisbane appears to be getting into trouble again. This time it is in regard to the water supply of the city. Last time, it was a matter of sewage. The Hon. W. F. Taylor, M.D., M.L.C., who is at the same time Medical Officer of Health, has charged the Board with supplying contaminated water. He ascribes an outbreak of enteric fever to the water supply. The report containing this serious charge was forwarded by the City Council to the Board, and the reply drawn on February 19, 1915, was to the effect that turbidity and contamination are two distinct things, and that there are other sources of enteric fever. It has further been announced that the water for the city of Brisbane will not be subjected to the process of filtering for at least two years. No mention is made of other methods of purification. The President of the Board stated that no complaints had been received "from the authorities who make the analyses," and that there is nothing to indicate that the water is impure. In the interests of the community, the bacteriological and chemical condition of the water must be disclosed, and if serious impurity exists, the Board must be held responsible for a neglect of its duty.



According to the *New Zealand Herald*, enteric fever has broken out among the members of the Maori contingent in the camp at Avondale. One Maori soldier has died of the affection. It is stated that all the members of the force will be inoculated with anti-typhoid vaccine before they leave Auckland. This work is being undertaken by the Health Department, and endeavours are being made to check the spread of the disease outside the camp.

Abstracts from Current Medical Literature.

THERAPEUTICS.

(57) Medical Therapeutics in 1914.

Wilcox (*Medical Times*, January, 1914) deals with the advances made in medical therapeutics during the year 1914. The subject of anoci-association is especially deserving of mention—local, combined with general anaesthesia constitutes what is termed anoci-association. The basis of this method is to prevent the loss of vital force from stimulation of brain cells through either the sensory or psychic system. The practical results are confirmatory. Wilcox deprecates the flamboyant exploitation of the *Dammerschlag*. The chemistry of the mydriatic alkaloids is not founded on a firm basis. Repeated injections of scopolamine in labour introduce an element of danger. From the maternal viewpoint, post-partum hæmorrhage and prolonged labour are apt to result. Increased risks of asphyxia and death threaten the child. The successful use of scopolamine requires (a) a high degree of technical knowledge of the drug and a special knowledge of the patient, (b) a marked degree of technical obstetric skill, and (c) uninterrupted attendance on the part of the physician during labour. In pure therapeutics the sensitized vaccines of Besredka constitute an important addition to our resources. The difficulties of the treatment of entamebic varieties of dysentery have been overcome by the subcutaneous injections of two to three grain doses of emetine. In the treatment of tetanus, antitetanic serum should be given by intraspinal injection. In severe cases it should also be given intravenously. He believes that the progress of the disease in *tabes dorsalis* may be checked by intra-spinal injections of salvarsan, combined with intra-muscular injections of mercury.

(58) Autogenous Vaccines in the Treatment of Sciatica.

Zapffe (*Journal American M.A.*, January 16, 1915) discusses the treatment of sciatica by means of autogenous vaccines. In his opinion the vaccine treatment of sciatica has not received the attention it deserves. Greeley cites one case treated successfully. The vaccine was made from a throat coccus. He gave only three injections. These cases open up a wide field for vaccine therapy. Good judgement must be used in the selection and treatment of cases. Zapffe narrates the history of a patient, aged 32 years, a commercial traveller, who consulted him because of an attack of sciatica. This attack had lasted, in practically unabated severity, for eight months. He had been under the continuous care of a number of physicians for the whole period, but without benefit. The whole gamut of treatment from the injection of spinal nerve roots with alcohol to the application of a Buck's extension apparatus had been tried. When Zapffe first saw

him he was hardly able to walk on account of the pain, nor could he lie down with comfort. Six weeks before the sciatica began he had an attack of gonorrhoea. Ten days after his doctor told him he was cured of his gonorrhoea he felt the first pain in his sciatic nerve. Careful physical examination failed to reveal the cause of the sciatica. His temperature varied from 98° to 99.8° F. A bacteriological examination of the urine was made. Staphylococci and diphtheroid bacilli were found. From a culture of these organisms a mixed autogenous vaccine was made. The first injection consisted of 100,000 bacteria. Six more injections were given. The final injection comprised 1,000,000 bacteria. After the fourth treatment the pain ceased entirely. The patient regained his normal weight, and made a complete recovery. Zapffe points out that good results can be obtained only from autogenous vaccines. Every other possible source of the sciatic pain should be investigated before vaccine therapy is tried.

(59) Opothrapy in Chronic Osteo-arthritis.

P. W. Roberts (*Monthly Cyclopedic and Medical Bulletin*, October, 1914) states that he has had excellent results in the treatment of chronic osteo-arthritis by the administration of thymus, thyroid, and pituitary glands, the application of d'Arsonval or bipolar high frequency currents, the reduction of calcium in the diet, and rest. He points out that no one of the glands alone is capable of regulating metabolism under all conditions. Thyroid should be used with care, especially in regard to dosage. The maximum physiological dose should be reached, and the drug then given in reduced quantities for a long period. Thymus gland is slow in its action, but is said to exercise a beneficial effect on osteo-arthritis. It is contraindicated in cases in which there is a rapid increase in weight. Fresh preparations should be used as the gland tends to deteriorate. The dose advised is from 10 to 15 grains. In regard to pituitary body, the author recommends intra-muscular injections of a 1 c.cm. of a 1% solution of the whole gland for two weeks, followed by 1 c.cm. of a 2% solution. During the exhibition of pituitary, the urine should be examined from time to time for sugar, and the blood pressure should be measured.

(60) Emetine in the Treatment of Sprue.

F. Schmitter (*Journal American Medical Association*, January 2, 1915) records that 12 cases of sprue have been treated in the United States Army, with emetine hydrochloride given hypodermically in doses of from 1/4 to 1 grain daily for five days. The symptoms cleared up under this treatment. In one case amebic dysentery complicated the attack. Schmitter gives the details of the only case in which it was possible to follow the clinical history for a sufficiently long time to gauge the ultimate results. In this case the patient was taken ill in Sep-

tember, 1906, his weight was 216 pounds. For seven years his bowels never acted normally, and vomiting was frequent. Sexual potency was lost early. He was placed under a variety of treatments up to September, 1913, but without any improvement. At this time he weighed 117 pounds. The emetine treatment was started, and improvement became manifest at once. After four months he weighed 156 pounds. Sexual potency returned, and the bowels became regular. All the symptoms passed off gradually, and after 11 months he had regained his previous good health.

(61) Galyt.

E. Brunor (*American Med.*, July, 1914) has used galyt in the treatment of syphilis, and reports favourably on his experience. Berumann, Mouneyrat and Tanon introduced in 1913 a chemical substance having the formula of *tetra-orydiphosphamino-diarsenobenzene*, which they re-named *galyt*. It is claimed for this substance that the neurotropic and congesting power is less than that of salvarsan. The toxic action on nerve tissue of organic arsenic compounds is not dependent on the arsenic content, as can be demonstrated in the case of the cacodylate of sodium, which is less toxic than "606," but contains 46% of arsenic, as compared with 35%. Galyt contains 35.3% of arsenic, is a yellowish green powder, and is odourless. It is freely soluble in alkaline solutions, but little soluble in water. The author dissolved 0.4 g. in 25 c.cm. of slightly alkaline water, and injected the solution intravenously. He used the injection in 10 cases of lues, and combined with it mercurial inunction and potassium iodide. The results were controlled by the Wassermann reaction. Clinical improvement followed the use of galyt in each case, and a marked effect on the Wassermann reaction was noted after 15 or 20 days. He attributes the tolerance to this preparation to its phosphorus content. In conclusion, he feels justified in recommending intravenous or intramuscular injections of this preparation.

(62) Fumigation with Cresyl.

Bouet and Roubaud recommended in 1911 fumigation with cresyl as a mosquito-killing measure. They suggested that 5 grammes per cubic meter sufficed, and pointed out that the cost worked out at less than 1d. per 1000 cubic feet. Harald Seiderlin (*Yellow Fever Bureau Bulletin*, September, 1914) has devised a method of evaporating cresyl for this purpose, for which he claims certain advantages. The cresyl was placed in glass retorts, the tubes of which pass through holes bored in the door of the room to be fumigated. The retorts were then heated in the ordinary way. After 10 minutes the fumes were seen to enter the room, and after a further 50 all the mosquitoes (*Stegomyia fasciata*) were found to be dead.

(63) The Treatment of Burns.

In dealing with the treatment of burns, Klauder (*Episcopal Hospital Reports*, 1914) advocates the Snede open method, in which occlusive dressings

are eliminated, and strict cleanliness, good drainage, and heliotherapy are carried out. The prognosis is not always easy to make. It is grave when one-third of the body in an adult, or when one-ninth of the body in a child is involved. Burns of the first degree are cleaned with normal saline solution and dusted with a bland powder. In burns of the second and third degrees, incision of the blebs and evacuation of their contents are indicated. All necrotic fragments of tissue and portions of clothing should be removed in third degree burns. In severe burns, the local treatment is of subsidiary importance. There is a considerable mass of evidence to show that death following burns is due to auto-intoxication. The exact nature of the toxin has not been determined. The treatment of a patient suffering from a severe burn is described as follows: In the first place, attention should be directed to the treatment of the shock. The local condition is of minor importance. The patient should be given morphine and, at appropriate intervals, strychnine, caffeine or digitalis. He is placed in bed between blankets, surrounded by hot-water bottles, and the foot of the bed is raised. Saline solution is administered subcutaneously, or by hypodermosynthesis or enteroclysis. Oxygen is given, preferably through the pulmotor. Large quantities of water are given by the mouth. He advocates sweats by means of the electric pack. When this is not obtainable, he immerses the patient in normal saline or normal bicarbonate of sodium baths, at a temperature of 100° F. for about half-an-hour. He starts the open method as soon as possible. The affected areas, protected by a cradle, are left uncovered. The lesions are exposed to the direct rays of the sun daily. Early skin grafts or covering with amniotic membrane is advocated.

UROLOGY.

(64) Essential Hæmaturia.

W. Spitzer (*Journ. Americ. M.A.*, December 12, 1914) discusses the etiology and treatment of essential hæmaturia. He defines the condition as a continuous, painless, renal hæmorrhage, of which the cause is not ascertainable by clinical investigation. He is of opinion that the changes found in the kidneys after removal are identical to those found in passive congestion, and he therefore concludes that the bleeding is due to passive congestion. The kidney is so constituted that bleeding necessarily takes place when it is passively congested. He states that the condition cannot be due to nephritis, because the clinical symptoms of nephritis are not present, and the urine is not of the type associated with an inflammatory affection of the kidney. In addition to this, he argues that nephritis cannot be unilateral, as this essential hæmaturia is. On the other hand, he admits that when the hæmorrhage continues for any length of time, the pathological changes approximate those found in a chronic interstitial nephritis. Passive congestion affecting

one kidney only is due to an obstruction to the outflow of blood in the kidney, which in its turn is caused by a twisting of the short pedicle of the organ. The author does not regard operative interference as justifiable unless the patient's life is threatened by increasing secondary anaemia. Bisection of the kidney should never be employed in the treatment of the hæmaturia. He is of opinion that it is highly dangerous. The operation that he performs consists in decapsulation and fixation of the kidney in its proper site.

(65) Cysts of the Prostatic Urethra.

Underhill has had two cases of cystic degeneration of the prostatic urethra under his care, and describes them in some detail (*Journ. Americ. M.A.*, January 24, 1914). This affection usually follows an inflammation of the urethra. The local symptoms are not very distinctive. They are usually the same as are met with in any long-standing chronic urethritis. The subjective symptoms met with in the two patients were characteristic of neurasthenia, which accompanies many cases of chronic affection of the posterior urethra. These symptoms were well marked in one of the patients, and caused the patient to seek advice. The author states that these neurasthenic symptoms are frequently met with in cases in which the *verru montanum* is involved in a pathological process. He asserts that this affection can only be diagnosed by endoscopic examination. The treatment advised consists in dilating the urethra and incising the cysts which have not collapsed under the control of the eye.

(66) Differential Diagnosis of Nephrolithiasis and Renal Tuberculosis by Röntgenography.

Krotoszyner (*Journ. Americ. M.A.*, December 5, 1914) holds the opinion that radiography may be of definite value on the local diagnosis of renal tuberculosis, for the purpose of determining the affected kidney, when other clinical methods fail. The differential diagnosis between nephrolithiasis and renal tuberculosis by means of Röntgenography alone is feasible only in so far as marked tubercular caseation of the kidney is concerned. It becomes difficult or may be impossible when one or more shadows are produced by calcified tubercular foci within the renal parenchyma. A careful and judicious interpretation of these shadows is essential, in order to avoid errors in the diagnosis of serious consequence. The author considers that pyelography may be of value in some cases, but is too dangerous to be employed as a routine method in all cases of renal tuberculosis.

(67) Cystoscopy in Vesical Tuberculosis.

Heitz-Boyer (*Journ. d'Urologie*, July, 1914) discusses the cystoscopic appearances in tuberculosis of the bladder. The bladder changes in this condition, when no secondary infection is present, are quite typical, and consist of granulations and ulcerative pro-

cesses. These typical appearances are only seen in early cases. When secondary infection is super-added, the condition is called "tubercular cystitis" and the cystoscopic picture is not characteristic. In regard to the manifestations of vesical tuberculosis he describes the granulations as small round protuberances in the mucosa in the neighbourhood of small blood vessels. They are of the size of a pin's head, have sharp outlines, are of a grey or yellowish grey colour, are slightly transparent and are surrounded by a slightly reddened zone or areola. The granulations are arranged around a blood-vessel, and are either single or multiple. They are usually seen in the neighbourhood of the ureteral orifice. In the next place, ulcers are met with. These ulcers have raised edges. They are crater shaped and the base is of a yellowish colour. They are surrounded by a zone of inflamed mucous membrane. The mucous membrane is further affected by typical ulceration. In this condition, the loss of substance is quite superficial and the base may even be heaped up above the level of the surrounding mucosa. The base is irregular, and is covered by yellowish material. The edges are often raised to a slight extent, and the tissue around is reddened. The rest of the mucous lining of the bladder is often quite healthy, but at times ecchymotic foci, caused by localized vascular injection, are seen. The mucous membrane at the ureteral orifices is usually the seat of marked injection, granulations, ulcers and bullous oedema, while sclerotic changes are not infrequently met with. It is necessary to distinguish granulations from the papules of granular cystitis, from bullous oedema, and from shreds of pus. Ulcers and the ulcerative process met with in vesical tuberculosis may be confused with the changes met with in simple cystitis, and carcinoma and syphilis of the bladder, as well as with simple ulceration. The combination of granulations, ulcers and ulceration, especially if these changes are localized around the ureteral orifices and at the fundus, while the rest of the mucous membrane of the bladder is healthy, speaks strongly in favour of this condition.

(68) Rosving's Operation for Congenital Cystic Kidney.

Lund has treated four cases of cystic kidney by Rosving's operation, and records his experience in the *Journ. of the American Med. Associat.*, September 26, 1914. This operation consists in a systematic puncturing of all the cysts until the kidney assumes its normal size, or nearly that size. Lund is of opinion that this operation is extremely useful, and he proposes to perform it in all cases in which the urinary secretion is not too greatly affected. He prefers to operate on one kidney at a time. The operation does not cure the patient, but it relieves him of his pain and of the dragging sensation, and improves his general health. It is effective in arresting the disease.

A NOTE FROM ALEXANDRIA.

By Lieut.-Col. John B. Nash, M.D., M.S.,
Sydney.

January 11, 1915.

Our good ship arrived at Port Said about 12.30 a.m. on the 13th inst. Twelve hours from end to end of the canal was a good performance. The Arab quarter of Port Said makes one marvel how people can live under all the disadvantages—what Australians call—resulting from overcrowding. The streets are narrow; never have been made. No four-wheeled ordinary vehicle could pass along many of them. A man with a broom makes attempts to sweep them; from his method of acting one might deduce that he had grown tired of his endeavours to remove the refuse and sand. Those which inhabit the streets are men, women, children (crowds of them), donkeys, goats, pigs, piggies, sheep (some black) and fowls. Without the use of the well known words of former days—*Gardez l'eau!*—dirty water, dust and other material is thrown over the upstairs balcony to the street below. Modern sanitarians impress upon us that the strict observance of the rules laid down is necessary to save us from being wiped off the face of the earth; yet here are a people breaking all the dicta, and who have been doing so for thousands of years, yet they still are breeding and thriving, closely huddled on a small island. They can do it. Food of various kinds is exposed for sale on the side of the street, or carried about in baskets. Mutton and pork, in carcase or cut up, hang on hooks, while a man with a bundle of twigs switches the flies away. How numerous these pests must be on a hot day 'tis not well to imagine. There must be people who buy the food as it is, else it would not be so exhibited by the owners. Just think of it! After six thousand years of history, the inhabitants have advanced no further in hygiene or sanitation.

The principal hospital at the Port is the one named "Egyptian Government Hospital," managed by the French Sisterhood of St. Vincent de Paul. An English lady is at present their superior. She has been in Egypt for nine years, and said "I have almost become an Egyptian." Her duties have been at Cairo and here. The buildings are old, in the centre of the town, and arranged round a small plantation of palms. In some of the wards, not lighted to the standard we demand, the beds are arranged in four rows, while in others one row is against either of the long walls. Women have small wards. There are three classes of patients. In the first was a British officer returning from India; he was attacked with dysentery when home-ward bound. In the second were non-commissioned officers who had been brought from the Punjab to do duty on the canal. In the third class were Arabs, Soudanese and the like. A small British hospital is also in working order. A large one of modern design and with fittings to suit is now being completed. It was said to us: "The Arab is a nomad by descent, and it is difficult to do anything for him in the way of scientific treatment."

The gonococcus of Neisser, and the trypanosomes, are said to be widely spread amongst the troops who are presently encamped in Egypt. Should we be landed in these parts it is to be hoped that our personnel will have more sense than to run the risk of becoming infected. How a white man, with the training given to individuals of our race, could run the risk in Port Said is difficult to imagine. If he does so one might reasonably ask: Is civilization in this respect a failure?

January 16, 1915.

The most interesting study on this earth must be the various sections of the genus homo, not necessarily from their more profound aspects, but from those which present themselves to the ordinary onlooker. Under different circumstances, and in varied climes interest is aroused by his colour, his clothes, his speech, his trading abilities, his features, his musculature, his carriage, his general appearances, his virtues, his failings, with the more than thousand and one other peculiarities which are the superficial appanage of each one, while he lives and fills the nich in the daily round into which he fits.

In the catacombs, the museum, and other places, he who wishes to probe beyond the grave, not being satisfied with

life's brief span, can find plenty of material ready to his hand whereon he can utilize his abilities, seeking to unravel the mysteries of the human race which lie wrapped in the material used in long ages ago to compass the bodies of the dead. Mummies, bones, are conserved in the museum, beside the handicraft in many ways of those who have lived adown the ages.

With his contagious diseases we are much concerned at present. Another warning wire has come from Cairo, telling of the large number of cases and the virulence of the venereal diseases. Special instructions have been given by senior officers to every man. It is to be hoped that notice will be taken and much trouble averted to the individual and the outfit as a whole.

At San Stefano, an Alexandrian suburb fronting the Mediterranean Sea, a casino is being utilized by doctors of the Indian Medical Service, with nurses and entourage; as a one thousand bed hospital for the reception of the sick and wounded of their comrades who are being sent on from Europe. It was intended that they should be in Brighton, England, but it is thought that this climate will be more suitable for them. The building covers a large area of ground; one frontage is to the waters of the Mediterranean Sea, which rolls up almost to the walls, the second is to a tram line, with electric cars direct from the city, some few miles distant. Patients should do well.

The ambulance trains are well fitted for the rapid and comfortable conveyance of both officers and rank and file. Each is complete in every detail, from the office to the lavatories. Cooking conveniences are as on a first class express. The designers have utilized the space available to the best advantage. The largest carriages have twenty beds in two tiers, arranged lengthways, the passage being along the centre for the whole length. The undersprings and the buffers appear to be of the best in quantity and quality, the whole being a truly modern means adopted to make less hard the journey of those who have fallen by the way and who are being transferred elsewhere for treatment and repair.

There is a large private hospital in Alexandria, styled "Deaconesses' Hospital, Alexandria." Before the outbreak of war it was under the supervision of Dr. Morison, an Aberdeen graduate, representing the British Government and sentiment, with a German doctor, acting similarly for his country's ideas. Two Germans were then in residence; they are now in Europe. The Scotch surgeon and his assistants are at the moment charged with the whole work. The sisters come from Germany, their head house being near Düsseldorf, on the Rhine. There is a bond of union between them which is not so binding as is that between the members of a Roman Catholic sisterhood, yet which serves to keep them working for a common end and as a united whole. The chief is, fortunately for them, British. There is nothing but flat surface in this part of the world; perforce, the building is upon a level area. White inside and out, it forms one side and part of two others of a square. Such conformation is common here for large buildings. It rises four stories from the top of the entrance stairs, the space beneath their level giving another floor. The appearance is imposing. Within, the floors are of white marble slates, the walls and ceilings painted shades of grey or grey blue, the entrance halls and corridors spacious in every direction, geometrical staircases, steps of white marble, winding from floor to floor. Many of the corridors have the one side enclosed with glass, on the outside being spacious balconies. The kitchen and laundry are on the ground floor, fitted with all up to date conveniences, the former connected by electric lifts with the various parts of the establishment. The patients are divided into three classes—1st, 2nd and 3rd: one per room, two per room, in a ward. Payments ranging from 12/- to 3/- of our money per day. For the 1st and 2nd the space is greater than is available in the highest class of private hospital in Australia. The sisters get for themselves a separate fee, ranging with the income of the patient, for each operation. The operating rooms are well equipped with the highest class of tables and other outfit, being far more spacious than in Sydney or Melbourne. There are adnexa, such as isolation ward, mortuary, etc. Several Governments subsidize with small amounts the

place, having the right to send their subjects as patients. From the architect's point of view, as a hospital one might criticize it in heaps of details, favourably and unfavourably, but in doing so one would require to remember the class of people for whom it has been built. These are for the most part Egyptian and people native to the Mediterranean littoral, with a sprinkling from the ships of all nations that come to the port. The cost was £70,000, which, in Australia, would mean £200,000 (about) to obtain a like building. It is paid for. Taken as a whole, it is a sample of Oriental magnificence, as applied to a hospital.

There are other hospitals in this city, but none on so pretentious a scale.

British Medical Association News.

MEDICO-POLITICAL.

A Council Meeting of the Victorian Branch was held at the Medical Society Hall on Thursday, February 11, 1915. Dr. A. V. M. Anderson was in the chair.

The name of Dr. R. H. Boyd was added to the Legislative Sub-Committee, which still has under consideration the Workers' Compensation Act.

Dr. G. A. Syme was nominated a representative of the group on the Council of the British Medical Association. This nomination was communicated to the General Secretary by cablegram. Dr. Syme was also appointed Representative on the Representative Body, and Drs. Hurley and Sutherland were appointed Delegates at the Annual Meeting.

In answer to communications from the Committee of the Yarram Hospital, the Council re-affirmed its position that it viewed with distrust the principle of using public funds towards the treatment of patients who are in a position to pay full fees for medical treatment.

The audited balance-sheet of the Compensation and Organization Fund showed that the trustees held bonds of a face value of £4150, and that divisible interest was £52 3s. 6d.

The much debated question of advertising in country newspapers was advanced a further step by the reference of the correspondence to the Ethical Sub-Committee, which will submit a report at the next meeting of the Council.

Delegates were appointed to meet those of other representative bodies to determine a date for the adoption of the new British Pharmacopoeia.

The Council adopted the principle submitted to it by the Legislative Sub-Committee that the Medical Bureau established in connexion with the Workers' Compensation Act is against the interests of the profession and of the public. The objection to the Bureau is one of principle.

With respect to the payment of £1 per annum for the *Journal*, the Council resolved to meet the wish of the Directors of the Australasian Medical Publishing Co. as far as possible, and authorized the Treasurer to make payments of 5/- per head per quarter for three quarters. If the Council finds at the end of the fourth quarter that it is financially able to make another such payment it will do so.

It was decided that the next Clinical Meeting should be held at the Melbourne Hospital.

The Annual Meeting of the Eye and Ear Section of the Victorian Branch was held on January 26, 1915, at the Eye and Ear Hospital, Melbourne, Dr. W. Kent Hughes in the chair.

The following Office-bearers for the year 1915 were elected:—

President: Dr. S. A. Ewing.

Honorary Treasurer: Dr. Norman E. Gibbs.

Honorary Secretaries: Dr. Leonard Mitchell and Dr. H. Barry Thomson.

Honorary Auditor: Dr. Stewart Fergusson.

Members of Committee: Dr. Edward Ryan, Dr. W. Kent Hughes.

A vote of thanks was accorded to the retiring office-bearers, and also to the Committee of the Eye and Ear Hospital, for the use of the Hospital for meetings.

The President, Dr. S. A. Ewing, referred to the duty of the section as a whole to subscribe to one of the War Funds.

The sum of ten guineas was voted to the British Medical Association (Australia) Motor Ambulance Fund.

Dr. Kent Hughes raised the question of eliminating "specialities" from the brass door-plates of members. The majority of the members present considered that the custom obtaining in Melbourne was a distinct advantage to the general public, and a marked convenience to members in limiting those seeking the advice of the specialist to persons who were suffering from affections included in the branch of medicine or surgery indicated.

An invitation had been received from the Council of the Victorian Branch by the Committee of the Eye and Ear Section to take charge of the scientific meeting to be held on March 3, 1915. It was decided that the subject for discussion at this meeting be "Discharging Ears and Their Intracranial Complications." The invitation was accepted.

A member had written to the Secretary, asking for information in regard to the proper fees to be charged by oculists. The Secretary reported that he had replied, informing the member that specialists fix their own scale of fees. He suggested that two guineas was a usual fee for a consultation at which the refraction was worked out.

The following have been elected members of the New South Wales Branch:—

Dr. William A. McDonald, State Hospital, Lidcombe.

Dr. Charles Henry Oliver, Sydney.

Dr. Karl F. C. Brunnich, Royal Prince Alfred Hospital, Camperdown.

Dr. John William Farrar, Royal Prince Alfred Hospital, Camperdown.

Dr. Stuart Millard Graham, Royal Prince Alfred Hospital, Camperdown.

Dr. H. Hastings Willis, Royal Prince Alfred Hospital, Camperdown.

Dr. Courtenay James Wiley, Royal Prince Alfred Hospital, Camperdown.

Dr. Robert Joseph Taylor, Royal Prince Alfred Hospital, Camperdown.

Dr. Norman Maxwell Gibson, Royal Prince Alfred Hospital, Camperdown.

Dr. Colin Anderson, Royal Prince Alfred Hospital, Camperdown.

Dr. Francis Temple Grey, St. Jude's Rectory, Randwick.

Dr. Gordon A. Renwick, Glebe Point.

Dr. George Dibbs Waldron, Royal Alexandra Hospital, Camperdown.

Dr. William Duncan Kirkland, Lithgow.

The following has been nominated for election to the New South Wales Branch:—

Dr. Sydney John Blumer, Bowraville.

The following member has been transferred to the New South Wales Branch:—

Dr. George Stanley Thompson, Muswellbrook.

BRITISH MEDICAL ASSOCIATION (AUSTRALIA) MILITARY MOTOR AMBULANCE FUND.

During the past fortnight the Honorary Secretary of the Federal Committee has received the sum of £26 16s. in subscriptions to the Motor Ambulance Fund. The total up to date is therefore £1390 15s.

	£	s.	d.
Members of the Eye and Ear Section, Victorian Branch, Melbourne	10	0	0
Dr. Black, J. P., Horsham, Vic. .. .	1	1	0
Dr. Cliphsham, J. B., Esk, Q. .. .	1	1	0
Dr. Elvins, H. B. F., Geelong, Vic. .. .	2	2	0
Dr. Gibbs, Norman, Melbourne .. .	1	1	0
Dr. Grigor, W. E., Sydney .. .	1	1	0
Dr. Holmes, H. G., Mosman, N.S.W. (2nd donation) .. .	2	2	0
Dr. Kennedy, J., Melbourne .. .	1	1	0
Dr. Parker, L. R., Sydney .. .	1	1	0
Dr. Wallace, J. A., Gladestown, N.S.W. .. .	1	1	0
Dr. Webb, F. E., Williamstown, Vic. .. .	5	5	0
	£26	16	0

Corrections.

Dr. Hurst, George, Blackheath, N.S.W. .. .	1	1	0
Dr. Taylor, C. J., Normanton, Q. .. .	3	13	6

Public Health.

THE HEALTH OF VICTORIA.

The following notifications have been received by the Department of Public Health, Victoria, for the week ended February 11, 1915:—

Area.	Diph- theria. Cs. D'ths.	Scarlet Fever. Cs. D'ths.	Enteric Fever. Cs. D'ths.	Pulmonary T'b'culosis. Cs. D'ths.
Metropolitan ..	35 4 ..	5 — ..	3 1 ..	20 8
Rest of State ..	46 — ..	6 1 ..	23 — ..	11 2
Whole State ..	81 4 ..	11 1 ..	26 1 ..	31 10

INFECTIVE DISEASES IN QUEENSLAND.

The following notifications have been received by the Department of Public Health, Queensland, for the week ended February 12, 1915:—

Diseases.	Cases.
Enteric Fever..	46
Diphtheria ..	34
Pulmonary Tuberculosis ..	14
Infantile Paralysis ..	10
Scarlet Fever..	6
Varicella ..	3
Erysipelas ..	1
Total ..	114

SMALL-POX IN NEW SOUTH WALES.

The number of small-pox cases reported to the Department of Public Health, New South Wales, for the week ended February 21, 1915, was as follows:—

	Cases.
City of Sydney and Metropolitan District ..	2
Country—Newcastle and District ..	7
Total ..	9

THE HEALTH OF THE HUNTER RIVER SANITARY DISTRICT.

The report of the Medical Officer of Health of the Hunter River combined sanitary districts for the year 1912 has just been issued. It is very regrettable that the difficulty of obtaining the information from which these reports are compiled should cause so long a delay. Inasmuch as a great amount of the information has already been published in connexion with fortnightly, monthly and annual returns, it would not serve any useful purpose to give a detailed summary of the contents of this report.

The first part deals with the vital statistics of the district. In the second chapter scarlet fever, diphtheria and enteric fever are discussed at length. In regard to the lastnamed disease, it appears that the incidence was low, only 132 cases having been reported, while the mortality was 13.6%.

The third chapter contains information in regard to the administration of the "Pure Food Act." Dairies and noxious trades receive attention, and the concluding chapter contains a record of the laboratory work carried out in connexion with the Public Health Department. A number of excellent graphic tables and curves are appended.

THE HEALTH OF THE NORTHERN TERRITORY.

The Medical Officer for the Northern Territory has announced that only one case of malaria has occurred during the year 1914. No leprosy exists in the Territory, and although suspicious cases have from time to time been examined, it appears that none of these patients have been affected by genuine leprosy. The district is fairly healthy, and tropical diseases do not present any special administrative difficulty. The annual report of the medical officer will be dealt with in a subsequent issue.

ANTI-TYPHOID INOCULATION.

On September 5, 1914, we called the attention of the practitioners of New South Wales to the offer of the Department of Public Health to supply anti-typhoid vaccine

free of charge for use among the inhabitants of affected districts. It was pointed out that the department would carry out the prophylactic treatment if private practitioners did not avail themselves of the opportunity of vaccinating their patients at a comparatively low fee. The attitude of the department apparently has not met with the full approval of practitioners in some districts. We learn that the Mayor of Botany had opened a dépôt for persons desirous of availing themselves of anti-typhoid inoculation free of all cost. This action on the part of the District Council has originated from an epidemic of enteric fever. A considerable number of cases had been notified, and the source of infection has, it is said, been traced in the majority of instances, to milk derived from one dairy. The Medical Officer of Health has taken certain steps to check the further spread of the disease. It is to be hoped that it is not too late for the practitioners in the Botany district to intervene, and to carry out the necessary protective inoculation in the course of their practices.

Arrangements have been made at the Adelaide Hospital for the preparation of anti-typhoid vaccine, and for the inoculation of soldiers. The hospital laboratory has been utilised for the purpose of preparing the vaccines. Up to the present 3,000 men have been protected. In addition 82 of the nurses of the hospital and a number of the medical staff have submitted themselves voluntarily to the procedure.

In his annual report for 1913, Dr. Hope, Medical Officer of Health, Western Australia, announced that an offer had been made to the employers of labour to supply a large stock of anti-typhoid vaccine at a nominal cost (see *Medical Journal of Australia*, September 19, 1914, p. 290). This offer has since been extended, and persons who are desirous of availing themselves of the protective power of the vaccine can undergo inoculation free of cost at the Health Department in Murray Street. This offer has recently been repeated in view of the increased incidence of enteric fever at this season of the year.

BATH ACCOMMODATION IN HOBART.

A proposal to erect a municipal bathing establishment in Hobart was discussed by the City Council on February 8, 1915. Alderman Stabb tried to induce the Council to spend the sum of £13,862 on the building of an establishment to contain municipal, Turkish and hot baths, and salt water swimming baths. He attempted to justify his scheme on the ground of personal hygiene, public health and convenience. The scheme which he put forward included the erection of shops. He was of opinion that a profit could be realized. The majority of the aldermen did not agree that the Council would be justified in spending so large a sum of money. Alderman Dunn pointed out that the baths at Domain and Sandy Bay could be extended, and that this would suffice for the needs of the people. The proposal was rejected. According to a leading article in the *Mercury* of February 9, 1915, the position in Hobart in regard to bath accommodation of houses is very unsatisfactory. It is said that less than half the number of houses connected with the sewage system have baths attached. The reason given for the erection of houses without baths is one of expense, and the *Mercury* is doubtful whether many of the tenants would use the baths if they had them. If the conditions are as bad as they are stated to be, the erection of a large bathing establishment would not effect the improvement aimed at. The City Council should utilize its powers to prevent builders from completing houses without providing adequate bathrooms, even if the cost of connecting the bath pipes with the house drain and the sewer were high. The people would soon learn to make good use of their baths.

Vital Statistics.

METROPOLIS OF SYDNEY.

The Government Statistician of New South Wales has issued his returns for the months of January, 1915, dealing with the vital statistics of Sydney.

The number of births registered was 81 less than the average number registered in January during the preceding

five years. The birth-rate per 1000 of population is equivalent to an annual rate of 26.97, as compared with 28.25 for the preceding five Januaries. The number of illegitimate births was 114, which is 36 below the average. Seventeen per cent. of the total number of births took place in hospitals and public institutions. There were 610 deaths registered during the month in the metropolis. Of this number, 334 affected males and 276 females. Both the actual number of deaths and the death-rate were considerably below the average for the corresponding month in the preceding five years. The death-rate, calculated as an annual death-rate, is given at 9.73 as compared with the average for January of 10.87. One of the persons who died was 90 years of age, and another 98. Of the total deaths, 42% occurred in hospitals or public institutions. One hundred and eighteen children under one year of age died during the month. The infantile mortality was 70 per 1000 births. This represents a very material decrease.

Of the causes of death, diseases of the heart and arterial system were the most frequent, 88 deaths having been recorded. The Statistician, as usual, classifies deaths from cerebral hæmorrhage and apoplexy under diseases of the nervous system instead of under diseases of the arterial system. The 88 deaths referred to did not include deaths from chronic renal disease. Forty-seven of these deaths were ascribed to organic diseases of the heart. Malignant disease accounted for 70 deaths. In 27 instances the new growth was situated in the stomach or liver. In 13 it was situated in the peritoneum or intestinal tract, and in 11 in the female genital organs. Of the infective diseases, tuberculosis heads the list with 32 deaths. Enteric fever caused 8 deaths, diphtheria 5, influenza 3, pertussis 2, tetanus 2, and malaria, measles, syphilis, and dysentery one each. Acute articular rheumatism is stated to have caused 5 deaths, while 3 others are ascribed to "purulent infections and septicæmia." The deaths due to diarrhoea and enteritis are not divided into infective and non-infective, but are tabulated in three groups, viz., "under 2 years of age," "over 2 years of age," and "due to alcoholism." The total number recorded was 58. Seven cases of appendicitis conclude the list of infective diseases causing death, with the exception of deaths in the puerperal condition.

The Statistician records 43 deaths as due to diseases of the respiratory system. It is impossible from the data available to analyse these deaths from the point of view of infectivity. Pneumonia, which may be regarded as a well-defined, infective disease, killed 20 persons. Bronchopneumonia caused 10 deaths, and bronchitis 8. It is not quite clear what is meant by pulmonary congestion and pulmonary apoplexy, which are said to have caused 3 deaths. Three women lost their lives in childbirth from puerperal septicæmia. In addition, 1 death is classified under the heading "puerperal phlegmasia alba dolens, embolus, sudden death," 1 was due to puerperal hæmorrhage, and 3 to accidents of pregnancy. It is unfortunate that the causes of death in connexion with pregnancy and the puerperal condition are tabulated in such a stereotype manner. The value of vital statistics is rendered nugatory unless the information is given in such a manner as to enable the hygienist to distinguish preventable deaths from those that cannot be prevented.

In regard to the causes of death affecting infants, we learn that premature birth resulted in 28 deaths. Congenital debility, icterus and sclerema caused 12 deaths; 5 were due to "other diseases peculiar to early infancy," 4 to injury at birth, and 2 to want of care. In 9 cases death was due to congenital malformations.

Naval and Military News.

In the *London Gazette* of February 18, 1915, a number of Australian military surgeons have received mention. It is with much gratification that we learn that Surgeon-General William Williams has been promoted to the rank of Honorary Surgeon-General in the British Army. This distinction is a fitting acknowledgment of the valuable services which he has rendered to his country.

Captain Arthur Martin-Leake, V.C., F.R.C.S., of Calcutta, has been granted a clasp for conspicuous devotion to duty at Zonnebeke. This honour is equivalent to a

second Victoria Cross. Captain Martin-Leake received his V.C. in the Boer War. The Medical School at University College, London, his colleagues in Calcutta, and indeed the whole of the British profession of medicine, will join in congratulating him on having gained this unique distinction.

The name of Captain A. Martin, of Palmerston, New Zealand, has been mentioned in Field-Marshal Sir John French's latest despatches.

It is with great regret that we have to record the death by drowning of Dr. G. W. M. Custance, Surgeon, R.N., who was attached to H.M.S. Hawke.

The death of Captain J. A. Terras Bell, M.D., M.S., of Christchurch, is announced. Captain Terras Bell was with the New Zealand Contingent of the Expeditionary Force to Egypt. He died in the Abassia Hospital on December 29, 1914.

We understand that the Director-General of the Medical Services has received the following message from the High Commissioner for Australia under date of February 6, 1915:

"Many nurses arriving here are unable to obtain any appointment, as only nurses certificated and trained at least three years in a general public hospital of over 100 beds possibly are eligible. Red Cross nurses coming unofficially, sent for military service, must be between the ages of 25 and 40, and bring, addressed to the chief matron, War Office, a sealed statement from the matron of a training school, recommending her as suitable for military nursing, and verifying full general training. Suggest you inform all nursing associations, and also, through the press, all hospitals."

We have great pleasure in recording the promotion of Mr. F. D. Bird, M.B., Ch.M., of Melbourne, to the rank of Consulting Surgeon to the British Army in Egypt. The importance of selecting surgeons of great experience and sound judgment for posts of this nature is quite obvious, and we beg to tender to both Mr. Bird and the Imperial Army our sincere congratulations. Only eight surgeons have been appointed to similar positions in the whole of the British Army.

The following appointments have been gazetted:—

Army Medical Corps.

To be Captains:

- Captain (provisional) T. M. Furber, Australian Army Medical Corps.
- Captain (provisional) J. R. M. Beith, Australian Army Medical Corps.
- Captain (provisional and temporary) L. W. Bond, Australian Army Medical Corps.
- Captain (provisional) F. McIntyre, Australian Army Medical Corps.

Hospitals.

BRISBANE GENERAL HOSPITAL.

At a meeting of the Committee of the Brisbane General Hospital, held on January 27, 1915, the Secretary submitted a report on the financial condition of the institution. At the end of the year 1914 the committee had an overdraft at the bank of £1514. All the accounts had been paid. He estimated the expenditure for the six months ending June 30, 1914, at £11,866. It would therefore be necessary to make provision for £13,380. His estimate of the income of the institution was £9000, which would leave a deficit of £4380. He pointed out that voluntary subscriptions had fallen off, as a result of the large call made on the public since the beginning of the war. On the other hand, he was confident that the money required for the upkeep of this excellent institution would be forthcoming when the position was thoroughly understood. He laid great stress on the fact that the administrator of the hospital, a surgeon, the chemist, some of the surgical dressers, and a number of the nurses were now serving with the colours. He appealed to the public to assist this great hospital over its difficulties during the next six months. If the money could be raised and the institution kept solvent up to July, he understood that the subsidy which the Government was prepared to pay would suffice for all reason-

able needs. The hospital's claim on the charitable public was undeniable, for it was doing its country's work under the greatest difficulty.

A HOSPITAL FOR TIMBER WORKERS.

On January 22, 1915, a deputation of representatives of the Jarnadup Mill, State sawmills and Warren Roads Board (W.A.), waited on the Honorary Minister for the purpose of asking the Government to erect and maintain a local hospital at Jarnadup, with the assistance of the inhabitants. It appears that plans have been prepared and have been submitted to the Government Architect, who approved of the same. It was suggested by the resident manager of the State sawmills that if the Government would subscribe £1,000 he would undertake the erection of the hospital using local timber. It was pointed out that the hospital would serve a population of about 1,000. The upkeep was estimated at about £450. In his reply the Minister made some very caustic remarks on the tendency of many people to regard hospitals as places which the Government would supply out of the public purse, and where free treatment could be obtained. These people were prepared to find money for almost everything else. On the goldfields and in some of the timber districts, however, he was pleased to find that the people were doing as much as could be expected of them. The Government was going to help those who helped themselves. Without giving any definite reply to the deputation, he left the impression that he would recommend the proposals made.

Medical News.

The Presbyterian and Scots Church Neglected Children's Aid Society has opened a new receiving home in Flemingston Road, North Melbourne. Her Excellency, Lady Helen Munro-Ferguson, performed the opening ceremony on February 18, 1915, in the presence of a large number of persons interested in the social welfare of children. Despite the claims of Ministers and Governments that the care, protection and provision of all classes of society are a State matter, private charity still finds much work to do. In the case of neglected, deserted and ill-used children, the State institutions receive valuable complementation from societies such as the Presbyterian and Scots Church Neglected Children's Aid Society. The receiving home has been erected at the cost of over £4000, and it is anticipated that it will prove large enough and well enough equipped to meet the demands put on it for some years to come.

The following notice, which appeared in the *Sydney Morning Herald* of February 22, 1915, is an excellent example of the credulity of our contemporary:—

SLEEPING SICKNESS.

Perth, Sunday.

William Goldwyer, 50, resident of Cottesloe, wandered away from home on January 29. Four years ago, in South America, he was stung by a tsetse fly. Since then he had suffered from sleeping sickness. Late last night he was brought to the city from the Darling Ranges, where a settler found him sleeping under the bush in a ravine.

Goldwyer says he had not the least idea where he had been since he felt an attack coming on at Cottesloe. He has now quite recovered. He says he hazily recollected in a subconscious sort of way having had drinks of water from time to time lately, but had had no food all the time. The barking of a settler's dog awoke him. He did not feel a great desire for food, but was given some by a settler. He describes the sensation as a feeling first of weakness, and then loss of will power, and an absolutely irresistible desire to sleep.

The publishers of the *Medical Directory* in London have determined to limit that portion of the publication which deals with practitioners resident out of Great Britain and Ireland to those in Europe and North Africa. This determination has been arrived at in view of the great increase in the number of practitioners resident outside the British Isles. We have now received the 1915 edition of the *Medical Directory*, and find that this policy has been put into

effect. Representations have been made to Messrs. Churchill and Co., the publishers, by an Australian practitioner, through the Business Manager of the British Medical Association (London), that this action is distinctly opposed to Imperial interests. We are pleased to be in a position to state that this firm, in spite of the fact that it publishes the directory as a private venture, has given a sympathetic hearing to the arguments used, and has decided to return in the next edition of the directory to the practice of publishing the names, addresses and qualifications of medical practitioners registered in Great Britain and Ireland, even if resident outside the British Isles.

Obituary.

OCTAVIUS VERNON LAWRENCE.

The medical profession in Victoria has suffered a severe loss by the death on February 7, 1915, of Dr. O. V. Lawrence, of Camberwell, Melbourne. O. V. Lawrence was born in Launceston, Tasmania, in 1836, and was the youngest son of William Effingham Lawrence. After passing through his school education, he matriculated at the Melbourne University, and graduated in 1868. Three years later he received the degree of M.D., being the first Melbourne student to take this degree. At the time of his death he was the oldest living graduate of his University.

During the early years of his professional career he was intimately associated with the work connected with the University, and with the Melbourne Hospital. In 1871 he followed Dr. W. Smith as Demonstrator of Anatomy, which position he retained until May, 1876, when he retired in favour of Dr. H. B. Allen. He then became Medical Superintendent of the Melbourne Hospital, and at a later date was elected an honorary physician to that institution. After serving his term of office as Medical Superintendent, he entered private practice at Fitzroy. His success in practice was due in part to his skill as a physician, but not less to his sympathetic manner and knowledge of his fellow men. In later years he took Dr. F. W. Morton into partnership, and their relations in this compact were unusually happy through a long number of years. In 1890 he retired from practice. During his long illness he was attended by his partner, and by Dr. Henderson, of Camberwell.

Dr. Lawrence was twice married. One of his sons, Dr. Herman F. Lawrence, is well-known to the profession in Melbourne, being in practice in Collins Street, Melbourne.

Correspondence.

SCOLLER'S PSYCHICAL THEORY OF HEREDITY.

Sir,—I was glad to read Dr. Litchfield's letter under the above heading in your issue of 13th inst., as I have been thereby afforded an opportunity of finding out where, perhaps, I have not been sufficiently clear and explicit.

I was not aware of any endeavour on my part "to establish a particular form of dualism," because my theory is based on a monistic conception, not only of the organism but also of the universe. But that monism is based, not on the unity of matter and force, but on that of the psyche or spirit. In fact, I hold the body to be merely the outside of the soul, so to speak, or the phenomenal aspect of that which is purely a noumenal entity. In the same way I hold the physical universe to be the visible body of God, the infinite Monas Monadum, or the great Heaven, Father of the ancient Argans, who comprehends within himself implicit being as well as all manifested existences. And this, I consider, is the Father in Heaven proclaimed by Jesus of Nazareth. Even Haeckel has been forced to acknowledge the existence of God, not as an external personality, but as a living Spirit or divine intelligence.

Now it is admitted by Lange in his "History of Materialism," as well as by other competent authorities, that consciousness and thought cannot be explained by the movements of material particles. It is my contention, therefore, that it is not the *brain* which thinks, but that it is the "ruling monads" of the organism which make use of the brain, or the organ of thought. This is clearly demon-

strated by facts connected with the phenomena of abnormal psychology. For these show that "secondary personalities" can take possession of the organism, and such secondary personalities, as a rule, have no consciousness of the thoughts and memories stored up in the normal personality. Thus it is evident that the brain does not secrete the memories or psychical experiences of the personality; but these are manifestly stored up in a psychical entity which makes use of the brain. Moreover, this is further shown by the fact that the normal personality, when it reasserts itself, begins from the exact point where it left off, the intervening period being a complete blank.

Dr. Litchfield considers that my theory involves a great and dangerous jump in the assumption of the existence of monads "which are drawn into the organism through the force of spiritual affinity." But surely Dr. Litchfield will admit that the organism is entirely composed of living entities (or cells) which lead their own particular lives, besides sharing in and contributing to the life of the organism as a whole. How then is he going to account for the existence of those living beings on rational and scientific principles, except upon the assumption that such living beings have been drawn into the organism through the force of spiritual affinity or spiritual attraction. The first two division cells may be understood as giving a separate embodiment to the two gametes or reproductive cells which formed the zygote with which embryogenesis begins. All the entities represented by subsequent cell-divisions must be accounted for, and we contend that it is neither rational nor scientific to assume that these are created out of the material particles of which the germ-plasm is supposed to be composed.

As regards Weismann's theory of the germ-plasm, I contend that the whole thing is a mere pseudo idea, of which no one is able to form any rational conception, either as regards its nature or its origin. Nor are we alone in this respect, for Yves Delage, who is said to be one of the most skilled zoologists of France, speaking of Weismann's biophors, says "If they are possible they are useless, if they are useful they are impossible." Again, E. B. Wilson, of Columbia University, says in regard to the biophor determinant theory, "It demands for the orderly distribution of the elements of the germ-plasm a pre-arranged system of forces of absolutely inconceivable complexity." Then again, Oscar Hertwig declares that the determinant theory cannot explain the essence of organic development, and that the fundamental assumptions on which it is based are philosophically erroneous (see "Problems of Life and Reproduction," by Marcus Hartog). In fact, I am convinced that Weismann's theories have only been accepted because they are believed to afford countenance and support to the materialistic convictions of modern scientists.

Of course, in giving a brief abstract of the new theory of Heredity which I have been working out for many years past, it was impossible for me to give more than a sketch of the conclusions at which I had arrived. These, however, will be found fully supported by facts and arguments drawn from many sources in my work on "Heredity: the Problem and its Solution," which I hope to publish shortly.

Yours, etc.,

Sydney (undated).

JNO. SCOLLER.

THE PROBLEM OF VENEREAL DISEASE.

Sir,—Now that the above problem is more than ever exercising the minds of the medical profession and public in New South Wales, every effort should be made to devise some scheme for the most effectual reduction of these diseases, especially of syphilis. Their total eradication, one fears, will not occur for many years while human nature remains such as it is.

The following scheme suggests itself to me:—

1. Syphilis should be made a notifiable disease.
2. Any form of treatment by chemists and quacks of either syphilis or gonorrhoea should be punishable by heavy fines. In many cases, as it is, a chemist gets an inkling of what the disease is from the doctor's prescription and the patient's statements, and then continues the treatment on his own for months or years after,

3. All patients who can afford to pay private fees should be treated by their own medical adviser. Those patients who are in moderate circumstances and cannot afford fees for pathological examinations, Wassermann tests, etc., should have same done by the Government Micro-biological Department.

4. The Department of Public Health should organize a sub-department for venereal disease. All notifications should be sent direct to the medical officer in charge of this sub-department, and thus there will be no violation of professional secrecy, as he will then be in the position of a consultant or of a partner in a practice who has access to all the case records. Instead of a system of hospital clinics for patients who cannot afford to pay private fees in which no names or addresses are taken, such patients should be treated by whole-time medical officers attached to the Government sub-department. These medical officers should have power to see that patients continue until a cure is assured, and they should be compelled to present themselves for re-examination when called upon. Herein lies the strength of this system as compared with the voluntary system of the hospital clinic, in which a patient is here to-day and gone to-morrow. If he fails to come again, nothing is done to follow him up and compel attendance until he is no longer a danger to the community. Another most important point is that the chief medical officer of the sub-department should communicate with medical advisers of all persons reported, so as to ascertain if they are continuing their attendance regularly, and if not, these patients should be followed up and compelled to continue their treatment to a safe and satisfactory issue.

In the scheme thus briefly outlined, it will be seen that there is no interference with the private work of the practitioner, and instead of a large amount of honorary work being done at hospital clinics, whole-time medical officers, who must be adequately paid, will be benefiting. They will be specialists in the work, just as we now have in our Public Health and Lunacy services. Lastly, and most important of all, the thorny question of notification is got over without any breach of professional secrecy. The notifications go to the chief medical officer alone, and do not pass through the hands of any lay secretary or clerk.

I am, etc.,

Parramatta (undated).

CUTHBERT HALL.

ALCOHOL AND THE WAR.

Sir,—The abuse of alcohol by some of the troops is causing astonishment and deep anxiety to many Australians. Hospital officers have special opportunity of seeing the damage done, the lasting evil wrought by the foolish intemperance of newly-enlisted men. Some of us here think that if we medical men who cannot go to the war will forswear all alcohol until the termination of hostilities, the most emphatic protest will have been given, the best lead towards temperance in the army made. At this month's meeting of the Adelaide Branch, members will be asked to consider the matter and to take such action.

I write in the hope that a similar move may be taken in all the States, and that the result may reward the self-denial involved.

I am, Sir,

Yours very truly,

BEN FOULTON.

North Terrace, Adelaide,

February 16, 1915.

P.S.—My attention has just been drawn to the advice of the Archbishop of Canterbury and the proposal of Sir Thomas Barlow, advocating total abstinence among all classes for the duration of the war.—*B.M.J.*, Jan. 9, p. 95. B.P.

Personal.

Dr. F. P. Sandes has removed to "Wyoming," 175 Macquarie Street, Sydney.

Dr. J. I. Moore (Commissioner for Public Health of Queensland) has returned from a six weeks' holiday, and has now resumed his duties.

Dr. Cyril Shepherd informs us that the announcement made in the *Medical Journal of Australia* of February 20, 1915, p. 187, to the effect that Dr. Edwards has been appointed Acting Inspecting Medical Officer of emigrant ships during the absence of Dr. Shepherd, is inaccurate. Dr. Shepherd has been acting temporarily for Dr. Aspinall, and it is as *locum tenens* to the latter that Dr. Edwards has been appointed. The source of our information was the Government *Gazette*, which, as a rule, is accurate.

Dr. William McCristal, late of the Adelaide Hospital, has removed to Burrenjack, New South Wales.

Medical Appointments.

Dr. Foote, of Thames, New Zealand, has been appointed medical superintendent of the Westport District Hospital. Dr. Hugh G. Allen has been appointed Ophthalmic Surgeon at the Newcastle Hospital.

Dr. J. Manning Hair, late Senior Resident Medical Officer of the Royal Hospital for Women, Paddington, Sydney, has been appointed to the Coast Hospital, Little Bay, during the absence of Dr. Furber on military duty.

Dr. H. F. Harvey, of Perth, Western Australia, has been appointed a trustee of the Public Library, Museum, and Art Gallery of Perth, Western Australia.

Dr. A. McGregor Grant has been appointed Medical Superintendent of the Auckland District Hospital during the absence of Dr. C. E. Maguire.

Medical Appointments Vacant, etc.

For announcements of medical appointments vacant, assistants, *locum tenens* sought, etc., see "Advertiser," page xi.

Department of Public Instruction, New South Wales, Medical Officer.

Proceedings of Australasian Medical Boards.

NEW SOUTH WALES.

The following persons have been registered under the provisions of the "Medical Practitioners Act, 1912," as duly qualified medical practitioners:—

Anderson, John Thomson, M.B., Mast. Surg., 1914, Univ. Sydney.
 Edwards, William Angwin, M.B., Mast. Surg., 1914, Univ. Sydney.
 McLennan, Simon, M.B., 1914, Univ. Sydney.
 Roberts, Alan Thomas, M.B., Mast. Surg., 1914, Univ. Sydney.
 Stack, Walter Jaques, M.B., 1914, Univ. Sydney.
 Thompson, George Stanley, Lic. R. Coll. Phys. Lond. 1906; Mem. R. Coll. Surg. Eng., 1906; Fell. R. Coll. Surg. Eng., 1911.
 Cosgrove, Charles, Lic. R. Coll. Phys. Edin., 1913; Lic. R. Coll. Surg. Edin., 1913; Lic. Fac. Phys. Surg. Glasg., 1913.
 Rooke, Thomas Albert Ernest, Lic. Lic. Mid. R. Coll. Phys. Irel., 1898; Lic. Lic. Mid. R. Coll. Surg., Irel., 1898.

For additional registration:—

Smith, Eric McLeod, M.D., 1912, Univ. Oxford.
 Dean, Arnold William, Mast. Surg., 1915, Univ. Sydney.
 Brunnich, Karl Ferdinand Christian, Mast. Surg., 1914, Univ. Sydney.
 O'Brien, Daniel Patrick, M.B., Mac. Surg., B.A.O., N.U. Irel., 1911.

SOUTH AUSTRALIA.

Under the provisions of the "Medical Act of 1880" the following have been registered as duly qualified medical practitioners:—

Strachan, James Charles, M.B., B.S., Adel., 1914.
 Turner, Charles Trevor, M.B., B.S., Adel., 1914.

TASMANIA.

The following have been registered under the provisions of the "Medical Act, 1908," as duly qualified medical practitioners:—

Macnamara, Leslie Osborne, M.B., Sydney, 1914.

Hayward, Arthur Ernest, M.R.C.S., Eng., 1884, L.S.A., Lond., 1884.

Diary for the Month.

Mar. 3.—Victorian Branch B.M.A., Monthly Meeting.
 Mar. 5.—Queensland Branch B.M.A., Monthly Meeting.
 Mar. 9.—Tasmanian Branch B.M.A., Monthly and Council Meeting.
 Mar. 10.—South Sydney Medical Association, Annual Meeting.
 Mar. 10.—Melbourne Pediatric Society.

Covers for binding the *Medical Journal of Australia* for 1914 can be obtained on application to the Manager, B.M.A. Building, 30-34 Elizabeth Street, Sydney. The price of a cloth cover is 2s. and of half leather 2s. 6d.

Important Notice.

Medical practitioners are requested not to apply for any appointment referred to in the following table, without having first communicated with the Honorary Secretary of the Branch named in the first column, or with the Medical Secretary of the British Medical Association, 429 Strand, London, W.C.

Branch.	APPOINTMENTS.
QUEENSLAND. (Hon. Sec. B.M.A. Building, Adelaide Street, Brisbane).	Brisbane United F.S. Institute. F.S. Lodges at Longreach. F.S. Lodges at Warwick.
WESTERN AUSTRALIA. (Hon. Sec. 230 St. George's Terrace, Perth).	Swan District Medical Officer. All Contract Practice Appointments in W.A.
NEW SOUTH WALES. (Hon. Sec. 30-34 Elizabeth Street, Sydney).	Australian Natives Association. Balmain United F.S. Dispensary. Burwood District F.S. Institute. Goulburn F.S. Association. Leichhardt and Petersham Dispensary. M.U. Oddfellows Med. Inst., Elizabeth Street, Sydney. N.S.W. Ambulance Association and Transport Brigade. N. Sydney United F.S. People's Prudential Benefit Society. Phoenix Mutual Provident Society. F.S. Lodges at Braidwood. F.S. Lodges at Casino. F.S. Lodges at Lithgow. F.S. Lodges at Mudgee. F.S. Lodges at Orange. F.S. Lodges at Parramatta, Penrith, and Auburn. F.S. Lodges at Wellington. Killingworth Colliery, Newcastle. Seaham Colliery No. 1, Newcastle. Seaham Colliery No. 2, Newcastle. West Wallsend Colliery, Wallsend.
SOUTH AUSTRALIA. (Hon. Sec. 3 North Terrace, Adelaide).	The F.S. Medical Assoc. Incorp., Adelaide.

EDITORIAL NOTICES.

Manuscripts forwarded to the office of this Journal cannot under any circumstances be returned.

Original articles forwarded for publication are understood to be offered to the "Medical Journal of Australia" alone, unless the contrary be stated. All communications should be addressed to "The Editor," "Medical Journal of Australia," B.M.A. Building, 30-34 Elizabeth Street, Sydney, New South Wales.

The following periodicals are required by the Librarian of the New South Wales Branch of the British Medical Association to complete the series for binding. Members who have borrowed these journals are requested to return them as soon as possible.

Lancet, November 7, 1914.
Lancet, November 14, 1914.

